

**REPORT TO THE TWENTY-FIFTH LEGISLATURE
STATE OF HAWAII
2009**

**PURSUANT TO SECTION 334-10 (E), HAWAII REVISED STATUTES,
REQUIRING THE STATE COUNCIL ON MENTAL HEALTH TO SUBMIT
AN ANNUAL REPORT TO THE GOVERNOR AND THE LEGISLATURE
ON IMPLEMENTATION OF THE STATE PLAN**

**STATE OF HAWAII
DEPARTMENT OF HEALTH
December 2008**

HAWAII STATE COUNCIL ON MENTAL HEALTH ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE

Legislative Session 2009

State and Federal Mandate

This annual report is in response to HRS 334-10 (e): "The council shall prepare and submit an annual report to the governor and the legislature on implementation of the statewide comprehensive integrated service plan. The report presented to the legislature shall be submitted at least twenty days prior to the convening of each regular session".

Under federal mandate (P.L.102-321, Sec. 1914, State Mental Health Planning Councils), the State Council on Mental Health (SCMH) is required to review plans and submit recommendations for modification, and monitor and review annually the allocation and adequacy of mental health services in the State. States are also required to review the annual AMHD/CAMHD Implementation Report of the State Plan.

SCMH Response to Review Implementation of the FY 2007 State Plan

In November 2007, the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) solicited the SCMh's review of the Implementation Report for the results of the FY 2007 State Plan. The Council's comments (Appendix I) included accomplishments and challenges for both Divisions:

Adult Mental Health Division

Accomplishments

- Capacity to measure two additional Evidence-Based Practices: 1) Integrated Treatment for Co-Occurring Disorders (IDDT) and, 2) Illness management and Self-Directed Recovery (IMSR);
- Various programs to address the needs of forensic consumers; and,
- Increase in the number of persons receiving Supported Housing and New Generation Medications.

Challenges

- Re-admissions to Hawaii State Hospital: Continue to focus on decreasing re-admission through use of best practices in forensic services, such as the pre-booking and diversion programs.
- An expanding population of new persons being served coupled with a workforce shortage: Develop workforce capacity through ongoing training.
- Assurance of consumer satisfaction in the face of an expanding population.
- Implementation of the State Plan despite termination of federal court oversight.
- Decreased support from Legislature: Continue to use every opportunity to bill for services through the Medicaid Rehabilitation Option.

Child and Adolescent Mental Health Division

Accomplishments

- Support of suicide gatekeeper trainings across the State;
- Innovative project to develop a video series highlighting social and emotional challenges of pre-school age children;
- “Children’s Mental Health Matters” public awareness activities; and,
- Specialized programs to provide outreach to homeless, transgender and rural youth.

Challenges

- Meet the needs of youth requiring Support for Emotional and Behavioral Development (SEBD) as they transition to adulthood.

SCMH Response to Review the FY 2009 State Plan (Federal Mandate)

In July 2008, the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) solicited the SCMh’s review and input on their respective State mental health plans. At that time, the SCMh provided advisory comments and recommendations for the AMHD and CAMHD State Mental Health plans. The SCMh’s comments and recommendations are included, along with the Behavioral Health Administration’s response to the State Council’s comments below:

SCMH Recognized Highlights of the Plan

2009 State Plan actions that were positively recognized by the SCMh included:

1. State Comprehensive Integrated Service Plan

Adult Mental Health Division (AMHD)

- Services initiated at the Honolulu Police Department’s Central Receiving Division (CRD);
- Community-based Fitness Restoration Program (CBFR);
- Conditional Release Tracking and Exit Support and Transition (CREST);
- Mental Health Court;
- Mental Health Calendars;
- Supported Employment (rewarding consumers outcomes);
- Inpatient Oversight;
- Case Management Resource Guide;
- Case Management and Support; Consumer Resource Fund (restructuring)

2. Children’s State Mental Health Plan:

Child and Adolescent Mental Health Division (CAMHD)

- Juvenile Justice Mental Health – Juvenile Drug Court and Girl’s Courts Programs;
- Development of a new category of Eligibility, “Mental Health Only”, for children not eligible through IDEA or Medicaid;
- Use of Parent Partners statewide, to train, provide outreach to, and support families;
- Implementation of Cross-system Training Initiatives;
- Development of a new tactic to work with youth, Transition to Adulthood at the community level.

3. Overall Comments:

The State would enhance communication with the State Council on Mental Health and community input through provision of plans and decisions on an ongoing basis, rather than a once per year review.

SCMH Indicated Concerns of the Plan

2009 State Plan issues and concerns indicated by the SCMH (bulleted and bold) included:

1. Adult Mental Health Division

- **AMHD discontinuance of Assertive Community Treatments (ACT) services (summary): Monitoring ACT for fidelity rather than clinical outcomes; the lack of use of community development and integration for ACT resources in a defined community; and need for consideration of payment for performance rather than unit rate services were indicated as concerns with ACT (summary).**

AMHD Response (summary):

Difficulties in achieving fidelity (integrity of clinical practice) to ACT according to the Evidence-Based model were explained in the FY 2009 State Plan under the "New Developments" section and in an AMHD staff presentation to the SCMH. The literature supports that if ACT is performed in such a manner that it meets fidelity, as measured by the Dartmouth Assertive Community Treatment Scale), positive outcomes such as reduced hospitalization would be achieved. Two studies are representative of the reasons for AMHD action to discontinue ACT. The first study demonstrated greater reductions in alcohol and drug use, higher retention in treatment and fewer hospital admission among persons in high fidelity programs than low fidelity programs (Hawaii's fidelity scores largely did not meet the minimum threshold for fidelity over the course of two years, with the exception of one team). The second study was representative of the services that the AMHD will provide in place of ACT- the Strengths-Based model of Community Based Case Management. Results of this study indicated that the Strengths-Based model demonstrated significant advantage over ACT in producing reduction of clinical symptoms, fewer negative symptoms and greater life satisfaction scores, attributable to more emphasis placed on consumer abilities and strengths. The ACT model was designed to be an all-inclusive, self-contained treatment program. One of the reasons for its discontinuance as a bundled service was that providers were purchasing community resources that the ACT Team should have provided.

- **Cross-walking the AMHD Array of Services with outcomes for each service and service utilization would have been helpful for the State to analyze prior to discontinuing ACT, and may still be helpful to maximize efficacious services to consumers, especially with the ongoing fiscal issues.**

AMHD Response (summary):

This is an area that the AMHD supports and is a key item on the agenda as a priority area for future action. However, there are concomitant issues in its implementation that require significant resources, such as adoption of a psychiatric scale to measure symptomatology.

- The State's discontinuance of ACT services and Community Based Case Management (CBCM) in the Waianae community required querying this community about what services were important to them. This is a community that requested their own Community Health Center. To discontinue this contract without seeking a community perspective (Homestead, Neighborhood Board, Queen Liliuokalani Children's Center, Ho'omau Ke Ola, Waianae Coast Comprehensive Health Center, Legal Aid, kupuna (elders), etc. undermines collaborative relations with the State in this community. The Council is concerned that community desires be respected. Mediation is strongly suggested. SCMH Minority Opinion (1) is that it would be difficult to perform mediation within a program that was discontinued.

AMHD Response:

The AMHD takes the Council's comments under consideration for future action. However, the only service being discontinued in the Waianae community is ACT, which is being discontinued statewide. All other AMHD services continue to be available to consumers in the Waianae area from providers located in the Waianae community and staffed by employees who represent the Waianae community.

- Preparation for CMHC CARF accreditation and Clubhouse accreditation has been ongoing for at least 3 years. Low staff ratios to consumers in the clubhouses have not been corrected. Private providers are allowed only one year to prepare and attain CARF accreditation. It is recommended that more Clubhouse staff be hired as required by the International Center for Clubhouse Development (ICCD) rules.

SCMH Minority Opinion (1) is that accreditation is only given for three years, and clubhouse staffing is a guideline of a 15:1 staff/client ratio, not a requirement.

AMHD Response (summary):

AMHD supports this recommendation, noting that several AMHD Clubhouses are not in compliance with recommended 15:1 ICCD consumer-to-staff ratios. This is a high priority in order that ICCD standards for clubhouses are met and maintained for ICCD certification. Overall, Clubhouse consumer-to-staff ratios have improved from 19:1 in FY 2006 to 18:1 in FY 2007.

- The State created the AMHD Mental Health Operations Center (AOC) Infrastructure for quick response to both natural and man-made disasters. This was based on the National Incident Management System. It provides for role assignments and planning for critical incidents or potential loss of providers. The State appears to be using this mode of operation to bypass community and settle contract disputes. Furthermore, the location of the AOC is impractical for the services it is intended to provide for natural and man-made disasters.

SCMH Minority Opinion (1) is that having lived through Hurricane Iniki, it is much easier to have one main source of information and communication with centralized guidelines and training. In addition, there is the question of the Council's comment on a subject (AOC) that was not mentioned in the Council meetings, negating accurate comment by the Council on this subject.

AMHD Response (summary):

The State routinely uses the NIMS approach to test its preparedness for disaster response through the use of "what if" disaster simulations. With the layoffs that have

been occurring over the last year (Aloha Airlines, Molokai Ranch, and AMHD's reliance on contracted providers, it was recognized there was need to test its ability to continue services if there was loss of a major contractual provider. As an island state, the limited number of providers which are available demands contingency planning for their loss. Use of the NIMS drill also assisted staff to become more familiar with the NIMS protocol in the event of any disaster. The AMHD Operations Center (AOC) (for disasters) is a team of people, not a place, and includes persons from across the Division who are in contact within any space available. However, the AOC has never held a meeting in the Waianae area, and the establishment of the AOC was unrelated to Hale Na'au Pono.

2. Child and Adolescent Mental Health Division

- **The State Legislature reduced CAMHD's budget. Reductions in the biennium budget will be offset with Federal Medicaid reimbursements and CAMHD's functioning as a behavioral health plan. There are major areas that CAMHD has identified regarding statewide implementation: Transition to Adulthood services; Trauma and Violence; Prevention and Early Intervention between the ages of 3- 9 years; Juvenile Justice and Mental Health; Homeless and At-Risk Children and Youth. The Council will continue closely monitoring and advocating at the Legislature.**

CAMHD Response (summary):

In response to the economic downturn and the resultant fiscal constraints, CAMHD is continuing to pursue federal reimbursement and is implementing cost-cutting measures.

- **CAMHD implements Child and Adolescent Service System Program principles (CASSP) in its system of service delivery. This is not necessarily the foundation for service delivery in the Department of Education (DOE). If this were the case, there would be a decreased amount of requests for Fair Hearings. The Council requests that CAMHD staff, family advocates, and providers continue to reinforce CASSP with the DOE line staff.**

CAMHD Response:

CAMHD had adopted and fully implements the CASSP principles throughout its system of care. CAMHD has shared and promoted the CASSP principles with all CAMHD partners and collaterals.

- **The Mental Health Transformation State Incentive Grant (MHTSIG) along with AMHD and CAMHD has initiatives regarding medical records. The Dikel Report (DOE-funded), needs to be reviewed in the context of sharing mental health, substance abuse, and HIV information protected under HIPAA with the DOE. Policies and procedures need to be enacted between all Departments accessing medical records. Parents need to be told when they are giving up certain rights to confidentiality when information is released from the DOH to the DOE.**

CAMHD Response (summary):

All sharing of information between departments is subject to the various federal and state rules and laws. In addition to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the US DHHS *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) which CAMHD complies with, there are a number of federal privacy related laws that apply to schools. These include the

Family Educational Rights and Privacy ACT (FERPA), Protection of Pupil Rights Amendment, and IDEA. Hawaii Revised Statutes Title 8, Chapter 34, also provides for the protection of educational rights and privacy of students and parents.

- **Both AMHD and CAMHD have implemented the ASIST training for suicide prevention which is another Evidence-Based Practice. The high rate of suicides in young Native Hawaiian males presents another cultural competency issue to address.**

CAMHD Response (summary):

The high rates of suicide ideation and attempts among Hawaiian youth and Native Hawaiian males were precisely the reasons why CAMHD began investing in suicide prevention three years ago. CAMHD began partnering with the Department of Health's Injury Prevention Program, recruiting representative from the Native Hawaiian community for the Suicide Prevention Steering Committee, tasked to develop a Five Year State Suicide Prevention Plan. Through the advocacy efforts of this Committee a Suicide Prevention Program was authorized by the Hawaii State Legislature two years ago.

3. **Child and Adolescent Mental Health Division and Adult Mental Health Division**

- **The Chief's Roundtable which was held on a monthly basis has been an avenue for consumers to connect with the Chief, which is empowering for consumers to know that they have been heard. Quarterly focus groups should not be in lieu of the Chief's Roundtable. Both the CAMHD and AMHD Chiefs would do well to hold monthly roundtable discussions with consumers and family members around the State. Family education and outreach services have been underutilized. Consideration should be given to broader community outreach and see it as an opportunity to inform the public about signs and symptoms of mental illness and substance abuse, how to support family members as caregivers, and support the consumers, etc.**

SCMH Minority Opinion (1) is that the AMHD Acting Chief is doing double duty and maybe the Council should wait to see what our new Chief will do.

AMHD Response (summary):

The State Plan did not indicate that the AMHD intends to substitute focus groups for the Chief's Roundtable. Quarterly focus groups are planned in addition to the Chief's Roundtable to assure the consumer's voice is heard on an ongoing basis. In addition, when the AMHD makes significant changes to programs, such as changes with regard to Case Management and ACT, special informational meetings are held to inform consumers. The Office of Consumer Affairs also intends to continue to provide outreach to consumers living in groups homes or at clubhouses and other facilities.

CAMHD Response (summary):

CAMHD has instituted measures to ensure family involvement in its system of care. CAMHD partners with the statewide family organization, Hawaii Families as Allies (HFAA), to ensure the involvement of the family voice in many aspects of its system of care. CAMHD also endeavors to keep stakeholders informed and involved by holding quarterly provider meetings, distributing quarterly newsletters, and inviting them to CAMHD trainings.

- **Both CAMHD and AMHD continue to expand its knowledge of Evidence-Based Practices. Culturally competent Evidence-Based services do not largely exist for Native Hawaiians and Asian/Pacific Islander groups. Imported mainland practices may not serve these groups and indigenous, local and/or community beliefs and practices need to be considered in outreach and service delivery.**

CAMHD Response (summary):

CAMHD's three imported major Evidence-Based Practices, Multi-Systemic Therapy (MST), Multi-Dimensional Treatment Foster Care (MTFC) and Functional Family Therapy (FFT) were established with infrastructure to assure fidelity to the model AND responsiveness to local issues. A Clinical Psychologist assigned to work with providers, consultants and trainers in implementation of MTFC AND FFT to assist clinicians to adapt the models to fit both CAMHD needs and local culture. Multi-year data from MST indicates it is successful with Hawaii families. A new training series teaching contracted providers to utilize Evidence-Based Practice elements in their work with CAMHD youth, may choose from an array of techniques designed to be responsive to individualized needs while still utilizing "what works" to address the mental health problem.

AMHD Response (summary):

In recognition of this need, the Mental Health Transformation Grant Workgroup #4 has proposed a collaborative including Native Hawaiians, Asians and Pacific Islanders whose charge will include determination of culturally appropriate practices with the capacity to become a reimbursable Evidence-Based Practice. Through the COSIG grant, the Behavioral Health Divisions have been working with Hawaiian and Pacific Islander community leaders to recommend culturally-informed practices for consumers with a co-occurring mentally ill substance abuse disorder (MISA) which are incorporated in the multi-year COSIG Strategic Plan. Also, a pilot project on Maui is being developed to provide more bi-lingual, multicultural services in the context of Community-Based Case Management services.

- **Trauma-informed system of care: AMHD is using and training on the Seeking Safety curriculum and CAMHD is using Dialectical Behavior Therapy (DBT). Both are Evidence-Based Practices. Policies and procedures need to be reviewed in the prevention of trauma and minimizing triggers. Besides seclusion and restraint these include admission and transfer and institutional requirements. Addressing historical issues of cultural trauma through culture-informed care is important.**

CAMHD Response (summary):

CAMHD is currently completing a four-year SAMHSA grant to develop alternatives to seclusion and restraint in hospital and residential programs. This has included the development of trauma-informed care with training for service providers, and consultation with four residential programs. CAMHD has also updated its Policies and Procedures to reflect trauma-informed care; is planning ongoing training; is expanding seclusion and restraint adoption with additional partners; and is incorporating the trauma-informed approach into CAMHD's foundation training for care coordinators.

AMHD Response (summary):

AMHD's plan, which was initiated in the spring 2008 and will be ongoing throughout 2009, is to review standards for a trauma-informed mental health system; conduct an assessment of needs and gaps; develop a plan to address gaps and implement the

changes necessary to transform the system to one that is trauma-informed and trauma-sensitive. Policies and Procedures, admission, transfer and discharge are just a few of the items that will be addressed in the overall trauma initiative.

Federal Mental Health Planning Directions

In May 2008, a SCMH representative to the annual Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), National Community Mental Health Block Grant Planning Conference reported to the Council membership the following federally recommended areas for consideration in planning:

- Expand efforts to develop a positive context in which veterans are encouraged to seek help. The stigma of seeking help for mental illness is especially relevant for returning veterans. Currently, Post-traumatic Stress Disorder (PTSD) is uncommonly high among this population and it affects family members.
- Hire consumers to help other consumers through development of new programs or by expanding presently operating programs.
- Develop micro-enterprises or consumer-run businesses.
- Further the development of consumers taking charge of their illness through inclusionary decision-making and programs such as Illness Management and Self-Directed Recovery (IMSR).
- Develop programs to address the needs of the teen to adult gap group (Young Adults in Transition).
- Address needs of the severe and persistent mentally ill elderly, including physical illnesses such as diabetes, heart disease and suicide.

SCMH: Areas of Recommended Need by County/Island

County Mental Health and Substance Abuse Service Area Board (SAB) Member Representatives who are also SCMH members reported on the FY 2008 needs of their respective service/island areas:

Hawaii County:

- Additional office space is needed for the Ka'u Clinic which is in poor condition; van transportation for consumers is needed since the present van is not in working order; and state cars cannot pass safety inspections due to their state of dilapidation.
- Jobs for Certified Peer Specialists.
- Sufficient health/mental health personnel to meet island's needs.

Kauai County

- Consumer transportation, especially in rural areas.
- AMHD service: Licensed Crisis Residential Services.
- Legal documents for consumers including both physical and mental advanced directives, wills, power of attorney and safe storage of such documents.

Lanai Island

- Permanent full time psychiatrist.
- Formal employment program for consumers.
- Transportation services for consumers.

Maui County

- Psychologist (vacant due to low salary).
- Sufficient personnel to serve aging Maui geriatric population with mental illness.
- Appropriately longer hospital stays at Maui Memorial Hospital's Molokini ward (mental illness) to prevent untimely crisis readmission.
- Timely assessment of mentally ill persons.
- Address child suicides.
- Assure adequate supervision of providers and provide state oversight of providers.
- ACT Program needs competent, responsible staff.

Molokai Island

- Child psychiatrist to prevent suicides and handle crises.
- Adult psychiatrist.
- Clubhouse (work-ordered day).
- Services for youth where few or none exist.
- Certified Peer Specialist jobs.

Oahu (City and County of Honolulu)

- Crisis beds.
- Enable consumers to retain housing.
- Information regarding use of Consumer Based Intervention Services, and Consumer Resource Funds.
- Promote the Certified Peer Specialist Program through development and by publicizing job opportunities and through provision of support to Peer Specialists.

These needs were identified as prevailing over two or more Service Areas:

- hiring of psychiatrists;
- prevention of suicides;
- crisis services, especially crisis beds,
- consumer transportation; and,
- provision of jobs and support for AMHD's Certified Peer Specialists.

SCMH Major Area of Focus and Concern

A major area of concern in FY 2008 as reflected in the SCMH minutes relative to implementation of the State Plan included the following:

AMHD Certified Peer Specialists

SCMH discussion of the three-year old Certified Peer Specialist Program elicited a number of questions and issues. These included:

- Receive ongoing information of all the Certified Peer Specialist training sessions in order that SCMH members may publicize the training to constituents and stakeholders.
- Ensure Peer Specialists living in rural areas have access to employment.
- Determine the reasons for which providers are not hiring Peer Specialists.
- Become informed of the sources of funding for Peer Specialists.
- Become informed as to how employment for Peer Specialists is supported by the AMHD.

Areas suggested by the SCMH membership for consideration in relation to the Certified Peer Specialist Program included:

- Inclusion of referrals from the Division of Vocational Rehabilitation.
- Linkage of the Peer Specialist program with Supported Employment through the AMHD's Statewide Service Director for Psychosocial Rehabilitation.
- Development of "permanent" civil service status for these positions.
- Development of a policy from top management stating that this is a needed service and how it should be implemented at each level of management.
- Assignment of number of peer specialist positions to islands, not only counties; and
- Consideration for solving the conflicts of interest issue of working for and receiving services by the same provider, especially in rural areas.

SCMH Goals

During the past six months, the SCMH has been working on goals that the membership will consider for future action. These goals are:

1. Educate Administration about the importance of addiction challenges being part of the SCMH agenda reports.
2. Ensure there is timely access to an array of services on each island that is consumer-driven, community-focused, evidence-based, culturally relevant, and island connected.
3. Advocate for culturally competent services that allow for provision of Hawaiian perspectives on healing.
4. Ensure providers are held accountable for delivering contracted services.
5. Maintain interagency focus on ensuring the health, self-determination and well-being of all individuals (including youth) and their families through promoting early proactive intervention and recovery-based supports in the community.
6. Support comprehensive services for youth still requiring care upon aging out of the CAMHD system.
7. Advocate for more types of transitional housing with sufficient supports.

Attachments

LINDA LINGLE
GOVERNOR OF HAWAII



CHIYOME LEINAALA, FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
ADULT MENTAL HEALTH DIVISION
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

STATE COUNCIL
ON MENTAL
HEALTH

July 29, 2008

Chair:
Ku'ulei A. Kiliona

First Vice-Chair:
Randolph Hack

Secretary:
Candace Sandal

Members:
Belinda Ann Anderson
Alan Buffenstein, M.D.
Arthur Cabatbat
Liesje Cattaneo, MSW
Gordon Michael
Durant
Peter Gonzalez
Donna Hansen
Alva Kaneaiakala, RN
Sandra Miyoshi
Paula Morelli, Ph.D.
Steven Shiraki, Ph.D.
Amy Tsark
Maile Watters
Noelani Wilcox, APRN
Carol Young

Ms. Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20850

Re: The Council's Recommendations and Modifications

Dear Ms. Orlando,

Hawaii's State Mental Health Planning Council, known in the islands as the State Council on Mental Health (the Council), is pleased to present you with their recommendations and modifications regarding the Hawaii State Plan for FY 2009. First though, we would like to explain that this past year found the Council taking a more active role, than in former years, with a desire to increase their role in FY 2009 by:

- Improving their duties of advocacy on behalf of persons with serious mental illness and/or serious emotional problems, and
- Requiring a closer working relationship with the State so that we may fulfill our duties to monitor, review and evaluate the allocation and adequacy of mental health services in the State, as outlined in Attachment A, Section 1914 of the Agreement outlining the duties of a State Mental Health Planning Council.

Despite the intended function of the Council, the State has presented some firm decisions in their Plan for the upcoming fiscal year that was not shared with Council members. Such actions stymie the Council in fully performing its advisory and advocacy duties. Ongoing open and clear communication with the exchange of ideas would aid in better decision making and planning. Having the current once-a-year planning review is less desirable, especially when the State's decisions are categorical and lack community input.

The following are the Council's responses to the State Plan for FY 2009:

The State Plan noted that with the ending of Federal court oversight and present economic conditions, there are difficulties in sustaining system of care improvements. Most notable:

1. Discontinuance of Assertive Community Treatment (ACT): As a Medicaid Rehabilitation Option (MRO) service was billed as Intensive Case Management because of a lack of clinical record documentation, the State paying \$2.7 million dollars for the past year without a federal match and an additional \$1.75 million of other services in addition to the ACT service array. It is also noted that not all ACT teams have achieved fidelity. The State is also anticipating an unbundling of ACT services.

Council Concern: Upon review of the State Plan the concern is monitoring for fidelity rather than clinical outcomes. The State subsidy of ACT services should have been a wake-up call to reconsider what was being monitored. Part of the ACT rate includes community development and usage of community resources that support recovery. With more community integration there would be a resulting decrease in ACT billing, but this can only occur if ACT is developing resources within a community. For this reason ACT team coverage needs to be within a defined community so that community development can occur. It is not clear to the Council how this was monitored for and the results. Although the MRO rate for ACT is based upon a unit rate it is time for the State to consider discussing with Medicaid other possibilities; e.g., paying for performance. The present method of billing reinforces billing for time spent, so that a large percentage of working time must be billed, which may lead to abuses in the system. Whereas unit rates work in clinic settings where providers have control of their environment, the very nature of ACT is community based and operates in the consumer's natural environment.

2. There is no mention of Adult Mental Health Division (AMHD) service array analysis, which would better inform decisions to cut services that are duplicative and less recovery-oriented. For example by reviewing Day Treatment and Intensive Outpatient Hospital and determining whether a more recovery focus would be achieved by increasing the availability of Psychosocial Rehabilitation.

Council Concern: A cross walking of the AMHD service array with outcomes for each service and service utilization would have been helpful for the State analyze prior to discontinuing ACT, and may still be helpful to maximize efficacious services to consumers, especially with the ongoing fiscal issues.

3. The State Legislature reduced Child and Adolescent Mental Health Division's (CAMHD) biennium budget. Reductions in the biennium budget will be offset with Federal Medicaid reimbursements and CAMHD's functioning as a behavioral health plan.

Council Concern: There are major areas that CAMHD has identified regarding statewide implementation of: Transition to Adulthood services; Trauma and Violence; Prevention and Early Intervention between the ages of 3-9 years; Juvenile Justice and Mental Health; Homeless and At-Risk Children and Youth. The Council will continue closely monitoring and

advocating at the Legislature.

EVIDENCE BASED SERVICES:

1. Both CAMHD and AMHD continue to expand its knowledge of evidence –based services. Culturally competent evidence based services do not largely exist for Native Hawaiians and Asian Pacific Islander groups.

Council Concern: Imported mainland practices may not serve these groups and that indigenous, local and or community beliefs and practices need to be considered in outreach and service delivery.

2. Trauma-Informed System of Care: AMHD is using and training on the Seeking Safety curriculum and CAMHD is using DBT. Both are evidence-based services.

Council Concern: Policies and procedures need to be reviewed in the prevention of trauma and minimizing triggers. Besides seclusion and restraint these include admission and transfer and institutional requirements. Addressing historical issues of cultural trauma through culture informed care is important.

Both AMHD and CAMHD have implemented the ASIST training for suicide prevention, which is another evidence-based service.

Council Concern: The high rate of suicides in young Native Hawaiian males presents another cultural competency issue to address.

COMMUNITY INVOLVEMENT:

The State's discontinuation of ACT services and Community Based Case Management (CBCM) services in the Waianae Community required querying this community about what services were important to them. This is a community that requested their own Community Health Center. To discontinue the service contract without seeking a community perspective (Homestead, Neighborhood Board, QLCC, Ho 'omau Ke Ola, Waianae Coast Comprehensive Health Center, Legal Aid, kupuna (elders), etc.) undermines collaborative relations with the State in this community.

Council Concern: The Council is concerned that community desires be respected. Mediation is strongly suggested.

ADULT MENTAL HEALTH OPERATIONS CENTER (AOC).

The State created the infrastructure for quick response to both natural and man-made disaster. This was based on the National Incident Management System. It provides for role assignments and planning for critical incidents or a potential loss of providers.

Council Concern: The State appears to be using this mode of operation to bypass community and settle contract disputes. Furthermore, the location of the AOC is impractical for the services it is intended to provide for natural and man-made disaster.

CONSUMER and FAMILY PARTICIPATION:

Participation of AMHD consumers is important in the design and implementation of recovery based

Ms. Barbara Orlando
July 29, 2008
Page Four

services. The Office of Consumer Affairs (OCA) will hold quarterly consumer focus groups in each county to identify consumer priorities regarding AMHD funded services including areas to address with the Service Area Administrators (SAAs). Family education and outreach services are provided through brochure distribution and family individual and group meetings.

Council Concern: The Chief's Roundtable that was held on a monthly basis has been an avenue for consumers to connect with the Chief, which is empowering for consumers to know that they have been heard. Quarterly focus groups should not be in lieu of Chief's Roundtable. Both the CAMHD and the AMHD Chiefs would do well to hold monthly roundtable discussions with consumers and family members around the State.

Family education and outreach services have been under utilized. Consideration should be given to broader community outreach and see it as an opportunity to inform the public about signs and symptoms of mental illness and substance abuse, how to support family members as caregivers, supporting the consumer, etc.

CMHC CARF ACCREDITATION, CLUBHOUSE ACCREDITATION:

Preparation for accreditation has been ongoing for at least 3 years. Low staff ratios to consumers in the Clubhouses have not been corrected.

Council Concern: Private providers are allowed only 1 year to prepare and attain CARF accreditation. It is recommended that more Clubhouse staff be hired as required in the ICCD rules.

CASSP PRINCIPLES:

CAMHD implements CASSP in its system of service delivery.

Council Concern: This is not necessarily the foundation for service delivery in the Department of Education (DOE). If this were the case there would be a decreased amount of requests for Fair Hearings. The Council requests that CAMHD staff, family advocates and providers continue to reinforce CASSP with the DOE line staff.

ELECTRONIC MEDICAL RECORDS:

The Mental Health Transformation State Incentive Grant (MHTSIG) along with CAMHD and AMHD has initiatives regarding medical records.

Council Concern: The Dikel report (DOE funded) needs to be reviewed in the context of sharing mental health, substance abuse and HIV information protected under the Health Insurance and Portability Act (HIPA) with the DOE. Policies and procedures need to be enacted between all Departments accessing medical records.

Highlights Noted in the State's Plan:

Of particular note are AMHD's Services at Honolulu Police Department's Central Receiving Division (CRD); Community-Based Fitness Restoration (CBFR) Program; Conditional Release (CR) Tracking

Ms. Barbara Orlando
July 29, 2008
Page Five

and Exit Support and Transition (CREST); Mental Health Court; Mental Health Calendars; Supported Employment (rewarding consumer outcomes); Inpatient Oversight; Case Management Resource Guide; Case Management and Support Services News; Consumer Resource Fund (restructuring).

For CAMHD the partnering in Juvenile Justice Mental Health in its Juvenile Drug Court and Girls Court programs; development of a new category of eligibility, Mental Health Only for children not eligible through IDEA or Medicaid; use of Parent Partners statewide to train, outreach and support families; implementation of Cross-System Training Initiatives; developing a new tactic of working with youth, Transition to Adulthood at the community level.

In concluding this section, the Council notes that the Hawaii Mental Health Transformation State Incentive Grant (MHTSIG) processes have proven to be the most successful. Their town hall meetings held throughout the island communities collected valuable input that has never before been achieved on such a grand scale. The detailed information has assisted the Council in decision-making and actions. Furthermore, the MHTSIG staff has worked closely with the Council by giving consistent clear updates and helpful materials to keep the Council informed of their activities and plans.

Summary:

The Council is taking a more active role, than in former years, with a desire to increase their role in FY 2009, by continuing to advocate for consumers and their right to recovery oriented services that preserves dignity and assures high quality care.

In the Council's advocacy role it supports both CAMHD and AMHD in their initiatives when it is on behalf of consumers and families. On occasion there has been disagreement as to the State's position on legislation and community response. Therefore, the Council encourages the State to work more collaboratively together, particularly on legislation and the various communities served.

Thank you for allowing the Council the opportunity to participate in the State Plan by giving recommendations and modifications.

Yours truly,

A handwritten signature in cursive script that reads "Ku'ulei A. Kiliona".

Ku'ulei A. Kiliona
Chair, State Council on Mental Health

LINDA LINGLE
GOVERNOR OF HAWAII



CHIYOME L. FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
ADULT MENTAL HEALTH DIVISION
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

August 20, 2008

Ms. Ku'uilei A. Kilion
Chair, State Council on Mental Health
P.O. Box 844
Volcano, HI 96785

Dear Ms. Kilion:

Thank you for your comments on behalf of the State Council on Mental Health regarding the State Plan for Fiscal Year 2009.

We appreciate the Council prefacing their comments on the State Plan that the membership will continue their commitment to advocate for the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) consumers and to more closely partner with the State. A collaborative partnership with the Council is highly valued by the State and takes on additional importance as we are required to plan with decreasing State resources.

The Council's comments on the FY 2009 State Plan are restated below with AMHD/CAMHD responses following each of the Council's concerns. These include:

Concern #1: The areas of monitoring ACT for clinical outcomes rather than fidelity; the lack of use of community development and integration for ACT resources in a defined community; and need for consideration of payment for performance rather than unit rate.

AMHD Response:

Concerning Assertive Community Treatment (ACT), the Council has been made aware of AMHD's struggles to provide ACT services to consumers as reflected in Ms. Krahn's June 10, 2008 presentation to the membership and explicated in the State Plan ("New Developments" section). Over a year ago, the former AMHD Chief, Dr. Hester, first apprised the Council on the difficulty in implementing ACT according to the Evidence Based Practice model. The literature supported that if ACT were performed with high fidelity to the model (as measured by the Dartmouth Assertive Community Treatment Scale); positive outcomes such as reduced hospitalization would be achieved. Two studies from a recent AMHD literature search may provide a helpful perspective on the reasons for our clinical decision-making in regard to discontinuing ACT. In one study, the relation between outcomes and fidelity was supported, as

evidenced by clients showing greater reductions in alcohol and drug use, higher retention in treatment and fewer hospital admissions in high fidelity programs than those in low fidelity programs¹. As you may recall from the State Plan, Hawaii's fidelity scores, for the most part, did not rise above the midrange over the course of two years of semi-annual ACT monitoring. With the exception of one team, the team scores do not even meet the minimum threshold for fidelity.

A second study was representative of the rationale for AMHD's movement toward a strengths-based approach to recovery planning which further empowers the consumer. In this study, which compared ACT and case management utilizing the Strengths model² to shape the recovery plan, hospital days were decreased in both models. However, the Strengths-based program demonstrated significant advantages over ACT in reduction of clinical symptoms, including significantly fewer negative symptoms and greater life satisfaction scores. These very significant outcomes appeared to be directly related to the emphasis placed on consumer abilities and strengths guiding and shaping the individual's recovery goals and supporting strategies. The direction towards increased consumer empowerment and self-directed recovery plans is expected to produce more positive outcomes through adoption of the Strengths-Based, team-driven Community-Based Case Management program. This is wholly in line with AMHD's mission, vision, values, and guiding principles for a recovery-oriented model of care.

Regarding your comment on development of integrated resources within an ACT Team's geographic community boundaries, AMHD would like to remind the Council that the ACT model was intentionally designed to be an all-inclusive, self-contained treatment service program. If consumers are appropriately screened for admission so that only those who meet the ACT admission criteria are admitted, and if the ACT team provides all of the services to consumers they are contracted to provide, there should be no need for other community mental health services outside of the ACT team. One of the reasons for discontinuance of ACT as a bundled service program was that providers were purchasing community resources that the ACT team should have provided.

Concern #2: There is a need to cross-walk the AMHD Service Array and service utilization with outcomes to maximize efficacious services for consumers.

AMHD Response:

The cross-walking of services with outcomes is an area which the AMHD supports. Although at first glance, it would appear that implementation in this regard could easily be initiated, there are concomitant issues requiring significant resources, i.e. adoption of a psychiatric scale to measure symptomatology. Nevertheless, integration of services with outcomes is an area recognized by the AMHD as a key need and is already on the Division's agenda as a priority for future planning, development and implementation.

¹ McHugo, G.; Drake, R.; Teague, G; and Xie, H. (June 1999). Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study. *Psychiatric Services*, 50: 818-824.

² Barry, K.; Zeber, B.; Zeber, J.; Blow, F.; and Valenstein, M. (2002) Strengths versus assertive community treatment: patient outcomes and utilization. *Abstr Acad Health Ser Res Health Policy Meet.* 19:15.

Concern #3: CAMHD budget

CAMHD Response:

In response to the economic downturn and the resultant fiscal restraints, CAMHD is continuing to pursue federal reimbursement and is implementing cost-cutting measures.

Concern # 4: Indigenous, local and/or community beliefs and practices may not serve Native Hawaiian and Asian Pacific Islander groups and need to be considered in outreach and service delivery.

AMHD Response:

Adoption of culturally competent services for Native Hawaiians, Asians and Pacific Islanders needs to be explored for their appropriateness, effectiveness and capability for being reimbursable. In recognition of this need, the Transformation Workgroup # 4 on Research and Evaluation has proposed a collaborative whose membership will include Native Hawaiians, Asians and Pacific Islanders and whose charge will include determination of culturally traditional practices and promising practices that may be able to meet the criteria to be designated an Evidence-Based Practice (EBP) ladder and become more widely reimbursable.

AMHD's actions to increase cultural competency within a recovery oriented system of care will be extended through the assignment of Mental Health Block Grant funds on Maui. A pilot project is being developed to develop more bi-lingual multi-cultural services to better serve Native Hawaiian, Asian and Pacific Islanders, especially in the context of Community Based Case Management.

Through the COSIG grant, the Behavioral Health Divisions under the Department of Health have also been working with Hawaiian and Pacific Islander community leaders and other representatives to recommend culturally-informed practices for approaching the treatment of consumers with both a mental illness and substance use disorder. A multi-year COSIG strategic plan has been developed that includes further development of culturally informed dual diagnoses treatments.

CAMHD Response:

CAMHD has imported three major evidence-based "packaged" programs - Multi-systemic Therapy (MST), Multi-dimensional Treatment Foster Care (MTFC) and Functional Family Therapy (FFT). As we implemented each program, we established infrastructure to assure fidelity to the model AND responsiveness to local issues. Currently, a CAMHD staff Clinical Psychologist has been assigned to work closely with the contracted providers implementing MTFC and FFT as well as with the companies that provide training and consultation on each approach. This Psychologist helps the clinicians implementing the model find ways to adapt it to fit both the local CAMHD system needs and the local culture.

In the case of MST, the first evidence based program brought to Hawaii, we now have many years worth of data to demonstrate that the approach is effective with Hawaii families. A number

of adaptations have been made in the way staff are trained to ensure that they understand local cultural practices and values and utilize local resources, while the major techniques and principles of the model have been preserved.

CAMHD is implementing a new training series to teach contracted providers to utilize "evidence-based practice elements" in their work with CAMHD youth. Instead of being trained to implement a standard treatment manual, providers are being taught to choose among an array of those techniques that are employed frequently in well-validated treatment protocols. This approach assures that providers can be responsive to the particular needs of an individual youth or family while still utilizing "what works" to address the mental health problems based on the research evidence.

Concern # 5: Policies and procedures need to be reviewed to prevent trauma, minimize triggers; be sensitive to admission, transfer and institutional requirements, and address historical trauma.

AMHD Response:

AMHD's plan, which was initiated in the Spring of 2008 and will be ongoing throughout FY 2009, is to review national standards for key components of a Trauma-informed Community Mental Health System, conduct an assessment of AMHD needs and gaps, develop a plan for addressing those gaps, and finally to implement the changes necessary to transform the system to one that is trauma-informed and trauma-sensitive. Policies and procedures; admission, transfer and discharge criteria and processes are just a few of the items that will be addressed as part of the overall all trauma-informed initiative.

CAMHD Response:

CAMHD is currently completing a 4-year SAMHSA grant project that focused on developing alternatives to seclusion and restraint in our hospital and residential programs. This initiative has emphasized developing trauma-informed care, and has provided a number of major trauma-focused training opportunities to service providers. This initiative included intensive consultation and technical assistance with four residential programs. All of these programs are evolving toward trauma-informed care, and are making progress in reducing seclusion, restraint and other coercive behavior management practices. CAMHD has updated its Policies and Procedures to reflect trauma-informed care. CAMHD's Practice Development Office will provide ongoing training activities and expand seclusion and restraint adoption with additional partners. The basics of a trauma-informed approach are being incorporated into CAMHD's foundation training for care coordinators and foundation training for providers.

Concern # 6: The high rate of suicide in young Native Hawaiian males presents a cultural competency issue to address.

CAMHD Response:

The high rates of suicide ideation and attempts among Hawaii youth and Native Hawaiian males in particular were precisely the reasons why CAMHD began investing in suicide prevention three

years ago. CAMHD began partnering with its Department of Health sister agency, the Injury Prevention Program. The Injury Prevention Program had long been active around the issue of suicide prevention, including establishing a Suicide Prevention Steering Committee and developing a Five-Year State Suicide Prevention Plan. When the Suicide Prevention Steering Committee was established, representatives from the Native Hawaiian community were specifically recruited, along with representatives from the neighbor islands, public and private health and mental health agencies, mental health advocacy groups, education, military, law enforcement and first responders. Among the members are: Native Hawaiian Ms. Pua Kaninau of the Queen Liliuokalani Children's Center who is a suicide survivor, Native Hawaiian Dr. Iwalani Else who is a faculty member of the University of Hawaii and researches indigenous health issues, and Mr. Dan Yahata who is with Kamehameha Schools, a private school system for Native Hawaiians. Through the advocacy efforts of the Suicide Prevention Steering Committee, a Suicide Prevention Program was authorized by the Hawaii State Legislature two years ago.

A major thrust of the Suicide Prevention Program is the series of Applied Suicide Intervention Skills Trainings (ASIST) gatekeeper trainings being conducted across the state. The ASIST gatekeeper trainings are designed to train participants to recognize and assess the risk of an individual in crisis and provide suicide prevention first-aid, thereby minimizing the suicide risk. Because participants go back to live and work in their own communities after the training, their knowledge and familiarity with their own communities enhance their ability to navigate within the cultural environment of local communities. Effort is made to specifically recruit from Native Hawaiian communities.

Concern #7: Discontinuation of services with the Waianae community required querying the community for their perspective to prevent undermining of collaborative community/State relations.

AMHD Response:

The AMHD takes the Council's comments under consideration for future action. However, AMHD would like to remind the Council that the only service that is being discontinued in the Waianae community is ACT, a service model that is being discontinued statewide. All other AMHD services continue to be available to consumers in the Waianae area, from providers located in the Waianae community, staffed by employees who represent the Waianae community.

Concern #8: The AMHD utilized a National Incident Management System approach to bypass community and settle contract disputes, and is located in an impractical area for the services it intends to provide.

AMHD Response:

The State routinely utilizes the NIMS approach to test its preparedness for disaster response through the use of "what if" disaster simulations. Council members have likely seen past television or newspaper reports of Statewide and Department of Health drills to respond to simulated hurricanes, pandemics, etc. However, all of those simulations assumed that AMHD

would be at full capacity and fully staffed to address those disasters. Over the past year, with the bankruptcy of Aloha Airlines, the massive layoffs at the Molokai Ranch, and AMHD's reliance on contracted providers for many of its services, AMHD recognized the need to also test its ability to continue to provide services to consumers if it lost significant provider capacity through various "what if" scenarios, such as a major provider declaring bankruptcy and shutting down operations. As an island state, the limited number of providers which are available demands contingency planning for their loss. The "what if" drill also assisted staff to become more familiar with the functioning of the National Incident Management System (NIMS) to become better prepared in the event of any type of disaster. The Adult Mental Health Division Operations Center (AOC) is a team of people and a process, not a place, for dealing with disasters at the Division level. The AOC team consists of AMHD staff from across all functional areas of the AMHD and meets whenever there is a need to test or update its disaster plan/process and meets wherever there is available meeting room space in a State building. The AOC has never held a meeting in the Waianae area and the establishment of the AOC was unrelated to Hale Na'au Pono.

Concern #9: Quarterly focus groups should not be held in place of the AMHD Chief's Roundtable. Both CAMHD and AMHD should continue with this practice for families and consumers on a monthly basis. Broader community outreach should be provided to inform the public and support consumers and caregivers.

AMHD Response:

The State Plan did not indicate that AMHD intended to substitute focus groups for the monthly Chief's Consumer Roundtable meetings. The quarterly focus groups are planned in addition to the Chief's Roundtable to provide greater opportunities for more consumers' voices to be heard. In addition, whenever AMHD makes significant changes to its existing service array, such as the introduction of Community Based Case Management in July 2007 and the unbundling of ACT services planned for August 2008, AMHD has scheduled a series of information and feedback meetings for consumers on all affected islands. In preparation for these meetings, flyers were sent to all consumers receiving those services that informed consumers of the meeting dates, location of these meetings, and provided a Frequently Asked Questions (FAQs) sheet in anticipation of any questions consumers may have. The Office of Consumer Affairs also intends to continue efforts to outreach consumers in the community through visits to group homes, Clubhouses, etc. over the next year.

CAMHD Response:

CAMHD has instituted measures to ensure family involvement in its system of care. CAMHD partners with the statewide family organization, Hawaii Families as Allies (HFAA), to ensure the involvement of the family voice in many aspects of its system of care. HFAA Parent Partners (family members of children who have experienced mental health challenges) are co-located at every branch. The Parent Partners are housed at each of the seven Family Guidance Centers and the Family Court Liaison Branch so that they can be immediately available to provide guidance and assistance to parents.

CAMHD incorporates the family voice in its leadership by specifying that management committees include Parent Partners as ex-officio members. For example, the Executive Director of HFAA is an ex-officio member of CAMHD's Executive Management Team.

CAMHD also endeavors to keep stakeholders informed and involved by holding quarterly provider meetings, distributing quarterly newsletters, and inviting them to CAMHD trainings. Additionally, CAMHD's community-based branches network within their own local communities, as resources are available. Therefore, depending on the location, branch staff can be involved in networking with the Department of Education, Department of Human Services, Community Children's Councils, local law enforcement, judicial systems, and/or other neighborhood-specific work groups.

Council Concern #10: It is recommended that more Clubhouse staff be hired as required in the ICCD rules.

AMHD Response:

AMHD supports this recommendation, noting that several AMHD Clubhouses are, in fact, not in compliance with the ICCD-recommended 15:1 consumer-to-staff ratio based on active membership. Furthermore, the CMHC System Administration has recently made it a high priority to acquire sufficient staffing to bring the non-compliant Clubhouses up to the ICCD standard in order to obtain and maintain ICCD certification and continue to provide quality services. As a result, the overall Clubhouse consumer-to-staff ratio has improved from 19:1 in FY 2006 to 18:1 in FY 2007.

Council Concern #11: CASSP Principles

CAMHD Response:

CAMHD has adopted and fully implements the CASSP principles throughout its system of care. CAMHD has shared and promoted the CASSP principles with all CAMHD partners and collaterals.

Council Concern #12: The Dikel Report need to be reviewed in the context of sharing mental health, substance abuse, and HIV information protected under HIPAA with the DOE, with enactment of policies and procedures between all Departments accessing medical records.

CAMHD Response:

All sharing of information between departments is subject to the various federal and state rules and laws.

After the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted, the U.S. Department of Health and Human Services established the *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule), to serve as a set of national standards for the protection of certain health information. A major goal of the Privacy Rule is to

Ms. Ku'ulei Killiona

August 20, 2008

Page 8

assure that individual's health information is properly protected while allowing health information to flow as needed to provide and promote high quality health care and to protect the public's health and well being. CAMHD complies with HIPAA and the Privacy Rule.

There are a number of federal privacy-related laws that apply to schools. They include the Family Educational Rights and Privacy Act (FERPA: 20 U.S.C. §1232g; 34 C.F.R. Part 99), which provides broad privacy protection for education records; the Protection of Pupil Rights Amendment, addressing education-funded surveys and studies; and the IDEA (34 C.F.R. §300.560 – 300.577), which provides additional protections to maintain the privacy of special education records. In addition, Title 8, Chapter 34 provides for the protection of educational rights and privacy of students and parents in the State of Hawai'i.

I would like to thank the State Council membership for their partnership with the State to advocate for provision of a recovery based system of mental health care. Your efforts are very much appreciated. Should you have any questions, or require further information, please call me at 586-4416.

Sincerely,

A handwritten signature in cursive script that reads "Michelle R. Hill".

Michelle R. Hill, Acting Chief
Adult Mental Health Division